

# New Hampshire Medical Eligibility Determination (MED) Application

Last:	First:	MI:	MID:	Date:
Referral Source: <input type="checkbox"/> Applicant <input type="checkbox"/> Guardian <input type="checkbox"/> Physician <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Family <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other				
Referral Agency/ Organization: _____		Name: _____		Phone: _____
Is this a transfer from a hospital to a Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		Swing Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of the facility requesting transfer: _____		Contact person: _____		Phone: _____
Projected Transfer/Discharge Date: _____		Is this a Medicare transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Office Use Only) Assessment Trigger: <input type="checkbox"/> 1. New Applicant: <input type="checkbox"/> 2. Reassessment due		LTC Nurse: _____		Phone: _____
Long Term Care Counselor: _____		ServiceLink: _____		District Office: _____
<b>DEMOGRAPHICS</b>				
1. SSN _____		3. Gender <input type="checkbox"/> male <input type="checkbox"/> female		
2. DOB _____		4. Age _____		5. <input type="checkbox"/> MR/DD <input type="checkbox"/> Serious MI
6. Mailing Address: (primary residence) Street _____ City _____ Zip _____ Phone _____ County _____				
7. Secondary Address: (if indicated for legal guardian) Street _____ City _____ Zip _____ Phone _____				
8. Marital Status: <input type="checkbox"/> 1. Never married <input type="checkbox"/> 3. Widowed <input type="checkbox"/> 5. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 4. Separated <input type="checkbox"/> 6. Civil Union				
9. Primary Language: <input type="checkbox"/> 1. English <input type="checkbox"/> 3. French <input type="checkbox"/> 2. Spanish <input type="checkbox"/> 4. Other: Specify _____				
10. Communication: <input type="checkbox"/> 1. No assist necessary <input type="checkbox"/> 3. Requires interpreter <input type="checkbox"/> 2. Requires Asst. Device <input type="checkbox"/> 4. Other: Specify _____				
11. Usual place of residence: A. Usual place of residence 1. Own Home <input type="checkbox"/> 2. Another's Home <input type="checkbox"/> 3. Adult Family Home <input type="checkbox"/> 4. Assisted Housing <input type="checkbox"/> 5. Congregate Housing <input type="checkbox"/> 6. Homeless <input type="checkbox"/>		B. Location at Assessment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Office Use Only)		A. Usual place of residence 7. Hospital <input type="checkbox"/> 8. Hotel/Motel <input type="checkbox"/> 9. Nursing Facility <input type="checkbox"/> 10. Residential Care <input type="checkbox"/> 11. Other: <input type="checkbox"/> Specify _____
		B. Location at Assessment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Office Use Only)		
12. Usual Living Arrangements: Lives with (check all that apply) <input type="checkbox"/> a. Alone <input type="checkbox"/> b. w/spouse <input type="checkbox"/> c. w/family <input type="checkbox"/> d. w/others                      e. # in household _____				
13. Medicaid Status: <input type="checkbox"/> Yes <input type="checkbox"/> No    1. Application filed?    Application date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    2. Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No    3. Eligibility pending?				
14. Physician: Type: <input type="checkbox"/> Primary                      Name _____                      Phone _____ Address _____                      Last visit date _____ _____  Type: <input type="checkbox"/> Specialist                      Name _____                      Phone _____				

